Health Services
LOS ANGELES COUNTY

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To improve health through leadership, service and education.

October 22, 2010

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **REPORT ON OLIVE VIEW-UCLA MEDICAL CENTER NEONATAL INTENSIVE CARE UNIT (NICU)**

On October 12, 2010 your Board directed the Department of Health Services (DHS) to provide a report back to the Board on the Center for Medicare & Medicaid Services (CMS) findings, and the facility's response, related to a survey of the Olive View-UCLA Medical Center NICU conducted on June 8, 2010.

The deficiencies identified by CMS were on the following subjects:

- NICU physician coverage
- NICU call schedule access
- Safety features of scales available in the NICU
- Breast milk receipt and storage
- Employee health screening

In response, the following corrective actions were submitted to CMS and implemented:

- Hired a Chief of Neonatology
- Hired additional Board certified physician coverage for the NICU
- Instituted a process for ensuring monthly call schedules are available
- Replaced scales in NICU
- Instituted new policies and procedures related to breast milk receipt and storage
- Instituted new polices related to patient safety in the NICU
- Addressed personnel issues related to this event
- Revised policies related to employee health services.

Corrective actions are being monitored for ongoing compliance. The CMS report (2567) is attached. Please let me know if you have questions or require additional information.

JFS:CR:mw

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050040	A. BUILDING _____ B. WING _____	C 06/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAC/OLIVE VIEW-UCLA MEDICAL CENTER	14445 OLIVE VIEW DRIVE SYLMAR, CA 91342

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a COMPLAINT VALIDATION survey for COMPLAINT NO: CA00228738. Investigation was limited to the complaint allegation(s) and does reflect the findings of a full inspection of the hospital. Representing the California Department of Public Health: Raul Reyes, HFEN; Terry Mc Elroy, HFEN; Susan Seyboth, HFEN, Barbara Mellor, HFES and Dr. Sanford Weinstein, Medical Consultant. The survey team entered the hospital on 5/12/10 at 1030 hours. The hospital identified their census at 194. CA00228747- THE DEPARTMENT SUBSTANTIATED THE COMPLAINT ALLEGATION(S) AND REGULATORY VIOLATIONS WERE WRITTEN AT ALL A TAGS IN THIS DOCUMENT. Glossary of Abbreviations: CCS - California Children Services CMO - Chief Medical Officer CQO - Chief Quality Officer CNA - Certified Nursing Assistant CT - Computerized Tomography Scan EBM - Expressed Breastmilk NICU - Neonatal Intensive Care Unit NNP - Neonatal Nurse Practitioner QAPI - Quality Assurance and Performance Improvement OB/GYN - Obstetrics/Gynecology	A 000	REVISED on 10/15/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 P&P - Policy and Procedure PPD - Purified Protein Derivative RN - Registered Nurse	A 000		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the medical staff failed to be accountable in updating the governing body regarding the NICU's current operational status and the quality of medical care being provided to it's patients. The failure to communicate the level of care being provided created a potential for harm to critically ill neonates who's care needs, in the absence of an in-house neonatologist, were more than the NICU personnel were qualified to manage. Findings: 1. Per review of the Guidelines for Perinatal Care; 6th edition; co-authored by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists, a national authority setting the standard for levels of perinatal care, the designations of levels of care were Level I - basic, Level II - specialty (NICU), and Level III (NICU) - subspecialty. * Level I neonatal care would have personnel and equipment to perform neonatal resuscitation, evaluate healthy infants and/or stabilize ill newborn infants until the necessary transfer to a higher level of care.	A 049	A049 MEDICAL STAFF ACCOUNTABILITY 1. CCS Designation Immediate and Permanent Corrective Actions The CEO sent a memo to all NICU staff to maintain the NICU at an intermediate level until the CCS application process (applying for Community status) was completed. Personnel from CCS performed an on-site review and audit of OVMCs compliance with their criteria The interim Medical Director hired a board certified Chief of Neonatology The Chief of Neonatology hired five additional board certified Neonatologists to provide coverage in the NICU, making 6 neonatologist available for coverage. The Chief of Neonatology received a letter granting conditional approval as a CCS Community NICU for 6 months beginning July 1 2010. The Chief of Neonatology received a letter granting conditional approval as a CCS Community NICU for 6 months beginning August 16, 2010. Persons Responsible: Interim Chief Medical Officer Chief of Neonatology Assistant Hospital Administrator	5-12-10 6-8-10 to 6-10-10 6-1-10 6-1-10 7-1-10 8-16-10

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A 049	Continued From page 2 * Level II nurseries could provide care to moderately ill infants who were expected to recover rapidly. This level of neonatal care was further subdivided into Level IIA and Level IIB. Level IIA would have no capability to care for infants needing assisted ventilation unlike Level IIB who could provide care with assisted ventilation for a brief duration. At a hospital with a Level II nursery, a board-certified obstetrician-gynecologist with a subspecialty in maternal-fetal medicine should be chief of the obstetric service. In a Level IIB hospital and above, a board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine should be chief of the neonatal care service. The hospital staff also should include a radiologist and a clinical pathologist who would be available 24 hours per day. Specialized medical and surgical consultation should be available. * Level III or a subspecialty NICU should care for severe high risk infants with complex and critical illnesses. A subspecialty NICU required it's personnel (neonatologist, neonatal nurses, neonatal respiratory therapists) to be continuously available to address neonatal emergencies. This level of care was further subdivided into Levels IIIA, IIIB and IIIC. Infants with birth weights equal to or greater than 1000 grams and/or gestational age was greater than 28 weeks should be in a Level IIIA NICU. Level IIIA should have the capability for minor surgical procedures such as central line insertion or inguinal hernia repair. Infants with less than 1000 grams and/or gestational age was less than 28 weeks should be in a Level IIIB NICU. This level of nursery should be able to care for infants requiring high	A 049	Monitoring Process Monitoring of CCS Status and maintenance of CCS designation is the responsibility of the chief of Neonatology. There are requirements in the CCS standards to provide reports and data regularly regarding standards compliance and neonatal outcomes. Once full, non-conditional approval is achieved, monitoring of compliance will be done by the chief of Neonatology with oversight by the Assistant Hospital Administrator. Information related to the admission and transfer of babies is monitored daily by the Chief of Neonatology.	ongoing

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A 049	Continued From page 3 frequency ventilation and nitric oxide. Infants requiring surgical interventions with cardiopulmonary bypass due to serious congenital malformations should be in a Level IIIC NICU, the most advanced level of neonatal care. Other neonatologists who practice in the subspecialty NICU should have qualifications similar to the chief of the service (board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine). A neonatologist should be available for consultation 24 hours per day. A neonatologist should be in-house to manage neonatal emergencies. On 6/2/10, review of the hospital's website indicated that since 7/8/05, the hospital's NICU was advertised as a community Level III (community) functional level. On 6/2/10 review of the California Children's Services website revealed the levels of neonatal intensive care were interpreted by CCS as Level II - intermediate, Level III A &B - community, and Level III C - regional. California Children's Services pays the hospital to provide care for neonates and designates which level of care can be provided in a CCS participating hospital. On 6/2/10, review of a memo of the same date by an Assistant Hospital Administrator revealed the following: On 9/14/09, the NICU Medical Director, a neonatologist, retired. On 9/15/09, a pediatrician who was board-eligible, not a board-certified neonatologist, became the Interim Medical Director for more than two months. On 11/21/09, a board-certified neonatologist assumed the role of the Medical Director.	A 049	A049 MEDICAL STAFF ACCOUNTABILITY MEDICAL STAFF COVERAGE IN THE NICU The interim Medical Director hired a board certified Chief of Neonatology The Chief of Neonatology hired five Board Certified Neonatologist to provide coverage for the NICU, who join the board certified neonatologist already on staff. Additionally, NICU coverage is also provided by hospitalists and nurse practitioners who have been granted NICU privileges by the medical staff. The Chief of Neonatology also arranged for board-certified/board eligible pediatricians to provide moonlighting coverage. There are now eight moonlighters available to provide coverage. All of whom have been granted privileges by the Medical Staff Association. The total complement of staffing available to provide coverage in the NICU is as follows: 7 Board Certified Neonatologists 8 Board Certified Pediatricians with NICU privileges 3 Hospitalists with NICU privileges 2 Neonatal Nurse Practitioner Standard staffing includes 2 hospitalists on for 7A-7P with a Neonatologist in house for days 1 hospitalist for 7P-7A with a Neonatologist on call. There is always a Neonatologist on call.	6-1-10 6-1-10 6-1-10 6-1-10 6-1-10 and ongoing

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A 049	Continued From page 4 Review of a notification letter from CCS addressed to the former NICU Medical Director, dated 11/20/08, revealed that the provisional approval for the hospital's NICU on a community level (Level III A&B) was changed to conditional approval as an intermediate (Level II) NICU for a period of four months due to staff qualification concerns, specifically the lack of neonatologists. Review of the hospital's table of correspondence with CCS from 2005 to 6/2/10 showed the hospital failed to comply with CCS' requirements to only provide an intermediate (Level II) NICU. Record review for 5 of 30 infants cared for in the hospital's NICU, revealed that the NICU continued to care for infants requiring Level IIB to Level III A&B care (Patients 1, 2, 5, 4, 7). On 6/2/10 review of the neonatologist's NICU schedule (3/10-5/10) and personnel record review revealed the hospital's NICU had one board-certified neonatologist alternating a weekly schedule with a pediatrician who was board-eligible, but not board certified, to be the neonatologist consultant. On 5/3/10, 5/30/10 and 5/31/10, there was no neonatologist coverage on the schedule for consultation. By the month of 6/10, the board-eligible pediatrician was on a leave of absence, leaving one board-certified neonatologist available for NICU consultation, but with no neonatologist in-house on a 7-day/24-hour basis to manage neonatal emergencies. In an interview with the NICU Medical Director, on 6/3/10 at 1330 hours, he stated that coverage provided by pediatrician hospitalists had been helpful but his schedule remained tight being the sole board-certified neonatologist available for	A 049	The chief of Neonatology prepares a monthly coverage schedule that provides for appropriate level of both in-house coverage by a practitioner with NICU privileges and on-call coverage by a board certified neonatologists which fulfills the requirements for Level III care. PERSONS RESPONSIBLE Chief of Neonatology Medical Staff Office Professional Staff Association (PSA) President MONITORING PROCESS On a monthly basis, the Chief of Neonatology will review the call schedule and verify that it is posted on the hospital intranet. If there are any deficiencies, he will notify the Chairman, Dept of Pediatrics, who, in turn, will notify both the Chief Medical Officer and the President of the PSA. Actions will be takent to correct any deficiencies. This monitoring process will continue indefinitely. The Nurse Manager of the NICU will be instructed to report any problems with the call schedule or problems with physician availability to the chief or Associate Chief of Neonatology the Chairman, Department of Pediatrics AND the President of the PSA who will be responsible for independently investigating and reporting any problems. The NICU nursing staff has been in-serviced on the role that the PSA President is playing in this process. The medical staff office monitors the credentialing and privileging of the practitioners responsible for NICU coverage.	6-1-10 and ongoing ongoing

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A 049	Continued From page 5 care and consultation. 2. During an observation tour of the NICU on 5/12/10 at 1120 hours, with the Medical Director of the NICU, the Director of Maternal Child, the Nurse Manager of NICU and RN 7, the call board at the nurses' station was observed. The call board listed all the physicians and NNPs working in the NICU. There was no information on the board to indicate who was the physician or NNP on-call or their contact numbers. When asked how staff would know whom to call in an emergency, RN 7 stated the name of the physician/NNP on-call was passed on at change of shift. When asked who was physician/NNP on-call at this time, the Director of Maternal Child and the Nurse Manager were unable to state. The Medical Director stated the call list was also on the hospital intranet. When asked, the Director of Maternal Child, the Nurse Manager of NICU and RN 7 stated they were not aware the call schedules were available on the intranet.	A 049	QAPI Program Immediate/Permanent Corrective Actions: OVMC Policy #130 "UHC Patient Safety Net Event Reporting System was reviewed by Quality Services & Risk Management. This policy requires reporting of events via the on-line PSN system. OVMC Policy #130 was revised to include requirements for managers to document reviews in the PSN and to include the reporting of events investigations and corrective actions to the Risk Management Committee quarterly. Nurse Managers were reminded to instruct staff to document events and actions taken in the patient's medical record Persons Responsible: Risk Management Committee Chair Risk Manager Chief Nursing Officer Nurse Managers Monitoring Process Event details will be reported Quarterly beginning November, 2010	6-11-10 9-22-10 7/27/10 11-10
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING [Performance improvement activities must track medical errors and adverse patient events, analyze their causes and] implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure the QAPI program for the NICU addressed two adverse patient events by comprehensively analyzing their causes and implementing preventive actions which included feedback and inservicing for the nursing staff in a timely manner. This resulted in the potential for	A 288		

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A 049	Continued From page 5 care and consultation. 2. During an observation tour of the NICU on 5/12/10 at 1120 hours, with the Medical Director of the NICU, the Director of Maternal Child, the Nurse Manager of NICU and RN 7, the call board at the nurses' station was observed. The call board listed all the physicians and NNPs working in the NICU. There was no information on the board to indicate who was the physician or NNP on-call or their contact numbers. When asked how staff would know whom to call in an emergency, RN 7 stated the name of the physician/NNP on-call was passed on at change of shift. When asked who was physician/NNP on-call at this time, the Director of Maternal Child and the Nurse Manager were unable to state. The Medical Director stated the call list was also on the hospital intranet. When asked, the Director of Maternal Child, the Nurse Manager of NICU and RN 7 stated they were not aware the call schedules were available on the intranet.	A 049	2. CALL BOARD MANAGEMENT Immediate/Permanent Corrective Actions The interim Nurse Manager re-organized the white board with all the MD/NP provider names and contact information. The Clinical Nursing Director sent a memo to all NICU nursing staff instructing them on how to access the NICU call schedule via the OVMC intranet. The change of shift hand-off process was revised to include review of the whiteboard and to ensure that the white board contains the correct names of on call staff. Monthly printed "on-call" sheets are posted in the NICU assignment book. The interim NICU Nurse Manager was instructed to report any problems with the call schedule or problems with physician availability to BOTH the Chief or Associate Chief of Neonatology, the Chairman, Dept of Pediatrics AND the PSA President who will be responsible for independently investigating and reporting any problems. The NICU nursing staff has been in-serviced on the role that the PSA president is playing in the monitoring process. NICU nurses were inserviced on the mechanism for reporting through the medical staff association, any problems with the call schedule. Persons Responsible NICU Nurse Manager Clinical Nursing Director PSA President Dept of Pediatrics Chairman Chief of Neonatology	5-12-10 5-12-10 5-12-10 5-12-10 9-17-10
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING [Performance improvement activities must track medical errors and adverse patient events, analyze their causes and] implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure the QAPI program for the NICU addressed two adverse patient events by comprehensively analyzing their causes and implementing preventive actions which included feedback and inservicing for the nursing staff in a timely manner. This resulted in the potential for	A 288		

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A 288	Continued From page 6 repeat incidents during weighin of infants. Additionally, this resulted in continued non compliance by nursing staff with the P&P regarding the collection, storage and handling of breast milk with the potential for error in administration to infants in the NICU for seven of 30 sampled patients (Patients 4, 6, 13, 16, 23, 25, and 28) . Findings: 1. On 5/12/10, the California Department of Public Health initiated a complaint investigation which included the allegation a NICU baby was dropped from the scale onto the floor during weighing on 3/14/10. During an interview with the CQO on 5/12/10 at 1150 hours, she provided an investigation report of the incident and confirmed Patient 2 was caught from an accidental slip off a scale on 3/14/10. A photograph of the scale involved showed two raised sides covering the length of the scale front and back. The ends of the scale were flat and open. The scale sat on top of a metal cart. The medical record for Patient 2 was reviewed on 5/12/10 at 1515 hours. The patient was born prematurely at a gestional age of 26 and 4/7 weeks (full term pregnancy is 40 weeks) weighing 995 gms (approximately 2 pounds). Review of the nurses' progress notes dated 3/14/10 at 2000 hours, showed documentation Patient 2 was bathed, weighed and redressed. "The bed linens were changed with the infant on scale #3, one hand on the infant and one hand tucking the sheet underneath the mattress, when	A 288	Monitoring Process At each change of shift, the charge nurse reviews the white board to ensure it contains the correct names of providers. The charge nurses co-sign the printed call sheet indicating they have read and verified who is on call. Random observational monitoring will be done by the Interim Nurse Manager and the Clinical Nursing Director by observing 10 change of shift hand offs. The Chief of Neonatology.in his monthly duty of preparing the NICU coverage schedule will ensure the call schedule is complete. Any problems will be reported to the Chairman, Dept of Pediatrics. This monitoring will be indefinite. The Nurse Manager, in his/her duties of ensuring that the Call Board correctly identifies the on call staff, will need to refer to the monthly NICU coverage schedule as posted on the intranet. If the Nurse Manager finds any problems with the call schedule, he/she will notify the Chief of Neonatology, the Chairman, Dept of Pediatrics, as well as the PSA president. This monitoring will continue indefinitely.	9-15-10 and ongoing

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A 288	Continued From page 7 the infant gave one big push and began falling to the floor. Was able to break part of the fall by grasping legs and buttocks. Upper back area actually touched floor." During a follow up interview with the CQO on 5/12/10 at 1515 hours, she stated signs had now been placed on the two sided scale instructing staff not to use it for larger infants. The CQO stated a four sided scale was available and was to be used for those babies over 3000 gms (6.5 pounds) and/or more than eight weeks old. When asked to provide a P&P developed to address the proper use of scales for use with babies, the CQO stated there was no policy at that time. The PI (Performance Improvement) notebook for the NICU was reviewed with the Director of Maternal Child Nursing on 6/3/10 at 0930 hours. In the area for reporting patient falls during the months of January, February and March, 2010, there were no reported falls. When asked regarding the fall of Patient 2 from a weighing scale on 3/4/10, the Director stated she was not sure if that incident was a "fall," that it was an event. When asked to define what else would constitute a fall when the patients in the NICU could neither ambulate nor sit up on their own, the Director then stated, "Yes, it was a fall." When asked, the Director stated the PI information from the NICU was compiled by the NICU Nurse Manager. The Director stated the Nurse Manager was aware there had been a fall in the NICU in March. During an interview with the CQO on 6/3/10 at 1055 hours, the Department of Nursing PI information for the first quarter of 2010, was presented. Review of the discussion and action	A 288	ACCIDENTAL SLIP OFF A SCALE Immediate/Permanent Corrective Actions The Clinical Nursing Director revised Policy 512 Patient Safety Measures in the NICU to include the statement that any infant weighing greater than 3000 grams or older than 8 weeks of life must be weighed on the four sided scale. The RN involved received a written confirmation of counseling letter. NICU staff were inserviced on the new policy requirements. The NICU PI first quarter report was revised to include actions taken to address the fall. The 2 sided scales in the NICU were replaced with all 4 sided scales. Persons Responsible Clinical Nursing Director NICU Interim Nurse Manager Monitoring Process Observational audits are conducted by the charge nurse to ensure that all infants in the NICU are weighed on the appropriate scale by the RN staff as required by policy. Audits are conducted twice weekly Results of these audits are reported to the NICU/Nursing performance improvement committee Audits will continue until monitoring demonstrates 100% compliance sustained over 2 months, then monitoring will be done quarterly.	5-25-10 5-25-10 5-13-10 5-18-10 8-2010 6-1-10 and ongoing

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A 288	Continued From page 8 recommendations during the meeting dated 5/4/10, showed the committee reminded the NICU representative a fall in the NICU had been reported in March, 2010. Action taken showed the NICU PI report would be revised. The information of a fall in the NICU was added to the Department of Nursing PI Report. A notebook containing documentation of NICU inservices was reviewed with the CQO on 6/3/10 at 1320 hours. Documentation showed nursing staff received formal inservicing on the use of scales for babies on 5/3/10 and 5/10/10. Included in the notebook was a memo dated 5/3/10, instructing staff to use the four sided scale for babies weighing more than 3 gms and/or more than eight weeks old. When asked why inservicing of staff was delayed for almost two months following the adverse event, she stated all staff were verbally reminded to use the four sided scale immediately following the event. The CQO stated, when the hospital received a formal complaint regarding the event in the beginning of May, 2010, they decided to take further action. At that time, she stated signs were placed on the two sided scale to remind staff not to use it for larger and older babies and inservicing of staff was initiated. 2. On 5/12/10, the California Department of Public Health initiated a complaint investigation which included the allegation that wrong breast milk was given to a NICU infant. During an interview with the CQO on 5/12/10 at 1100 hours, she confirmed on 3/4/10, Patient 1 was fed breast milk not from the patient's mother. On 5/12/10 the hospital's P&P, Collection,	A 288		

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A 288	Continued From page 9 Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, was reviewed. The purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Documentation showed upon transfer of breast milk to feeding containers and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. This would be documented on the 24 hour nursing flow sheet. In addition, breast milk bottles would be accepted on admission/transfer from other hospitals provided they were properly labeled. Patient 1's medical record was reviewed on 5/12/10 with the CQO. Review of the NICU 24 hour Nursing Flow Sheet dated 3/14/10, showed expressed breast milk was used for feedings. The CQO confirmed there was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID band of Patient 1 before administration to the baby at 1800 hours. A notebook containing documentation of NICU inservices was reviewed with the CQO on 6/3/10 at 1340 hours. Documentation showed nursing staff received formal inservicing on the collection, storage, and handling of expressed breast milk on 5/6, 5/10, 5/19 and 5/24/10. When asked why inservicing of staff was delayed for two months following the adverse event, she stated the information was given to the staff informally at first. The nurse involved was verbally counseled immediately. The CQO stated when the hospital	A 288	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing

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A 288	Continued From page 10 received a formal complaint regarding the event in the beginning of May, 2010, they decided to take further action. Formal inservicing was presented to the staff at that time. The PI (Performance Improvement) notebook for the NICU was reviewed with the Director of Maternal Child Nursing on 6/3/10 at 0930 hours. Review of the March 2010, PI findings showed an error in administration of breast milk. Actions taken were verbal counseling of the staff involved and reminder to all staff to follow the P&P for breast milk administration. There was no documentation to show plans to monitor staff for compliance. Medical record reviews were initiated on 6/3/10, for NICU Patients 4, 6, 13, 16, 23, 25 and 28. The 24 hour Nursing Flow Sheets for the infants during the months of March, April, and May, 2010, were reviewed. Documentation did not show licensed nurses consistently followed the P&P by double checking the label on the breast milk container with the identification of the infant. See A405.	A 288	Auditing for each of these measures will continue as such until 100% compliance has been sustained for 2 months. After 2 months of sustained compliance monitoring will be done quarterly.	
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on observation, staff interview and record review, the medical staff failed to demonstrate responsibility to the governing body (GB) for the quality of medical care as shown in the operation of the Neonatal Intensive Care Unit (NICU).	A 338		

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	A388 The organized medical staff is responsible for the quality of medical care provided to the patients. Specific corrective actions relative to findings are provided on the following additional page 12's.	
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	A049 MEDICAL STAFF ACCOUNTABILITY 1. CCS Designation Immediate and Permanent Corrective Actions The CEO sent a memo to all NICU staff to maintain the NICU at an intermediate level until the CCS application process (applying for Community status) was completed. Personnel from CCS performed an on-site review and audit of OVMCs compliance with their criteria The interim Medical Director hired a board certified Chief of Neonatology The Chief of Neonatology hired five additional board certified Neonatologists to provide coverage in the NICU, making 6 neonatologist available for coverage.	5-12-10 6-8-10 to 6-10-10 6-1-10 6-1-10
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347	The Chief of Neonatology received a letter granting conditional approval as a CCS Community NICU for 6 months beginning July 1 2010. The Chief of Neonatology received a letter granting conditional approval as a CCS Community NICU for 6 months beginning August 16, 2010. Persons Responsible: Interim Chief Medical Officer Chief of Neonatology Assistant Hospital Administrator	7-1-10 8-16-10

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	Monitoring Process Monitoring of CCS Status and maintenance of CCS designation is the responsibility of the chief of Neonatology. There are requirements in the CCS standards to provide reports and data regularly regarding standards compliance and neonatal outcomes. Once full, non-conditional approval is achieved, monitoring of compliance will be done by the chief of Neonatology with oversight by the Assistant Hospital Administrator. Information related to the admission and transfer of babies is monitored daily by the Chief of Neonatology.	ongoing
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347	A049 MEDICAL STAFF ACCOUNTABILITY MEDICAL STAFF COVERAGE IN THE NICU The interim Medical Director hired a board certified Chief of Neonatology The Chief of Neonatology hired five Board Certified Neonatologist to provide coverage for the NICU, who join the board certified neonatologist already on staff. Additionally, NICU coverage is also provided by hospitalists and nurse practitioners who have been granted NICU privileges by the medical staff. The Chief of Neonatology also arranged for board-certified/board eligible pediatricians to provide moonlighting coverage. There are now eight moonlighters available to provide coverage. All of whom have been granted privileges by the Medical Staff Association. The total complement of staffing available to provide coverage in the NICU is as follows: 7 Board Certified Neonatologists 8 Board Certified Pediatricians with NICU privileges 3 Hospitalists with NICU privileges 2 Neonatal Nurse Practitioner Standard staffing includes 2 hospitalists on for 7A-7P with a Neonatologist in house for days 1 hospitalist for 7P-7A with a Neonatologist on call. There is always a Neonatologist on call.	6-1-10 6-1-10 6-1-10 6-1-10 6-1-10 and ongoing

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347	The Nurse Manager of the NICU will be instructed to report any problems with the call schedule or problems with physician availability to the chief or Associate Chief of Neonatology the Chairman, Department of Pediatrics AND the President of the PSA who will be responsible for independently investigating and reporting any problems. The NICU nursing staff has been in-serviced on the role that the PSA President is playing in this process. The medical staff office monitors the credentialing and privileging of the practitioners responsible for NICU coverage.	

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	Auditing for each of these measures will continue as such until 100% compliance has been sustained for 2 months. After 2 months of sustained compliance monitoring will be done quarterly.	
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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			Permanent Corrective Action CCS conducted a survey to assess the NICU's compliance with criteria related to the different levels of care.	6-10-10
			CCS granted OVMC conditional approval as a CCS Community NICU for six (6) months	7-1-10
			The Governing Body was updated on the status of the NICU's current operational status and the quality of medical care provided to its patients at a meeting.	5-18-10
			Persons Responsible Interim Medical Director Chief of Neonatology Chief Executive Officer	
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347	Monitoring Process Monitoring of CCS status and maintenance of CCS designation is the responsibility of the Chief of Neonatology. There are requirements in the CCS standards to provide reports and data regularly regarding standards compliance and neonatal outcomes. Once full, non conditional approval is achieved, monitoring of compliance will be done by the Chief of Neonatology with oversight by the Assistant Hospital Administrator. Any changes in CCS status will be communicated to the Governing Body via the regularly scheduled quarterly meetings.	

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	2. NICU STAFF Permanent Corrective Actions The interim Chief Medical Officer hired a chief of Neonatology The chief of Neonatology hired five (5) additional NICU board certified staff to address the staffing needs of the NICU The Medical Executive Committee approved the appointment of these physicians. There are now a total of seven (7) board certified neonatologists, who provide in house and on call coverage, as mandated by the Level III status, who are assisted by 12 hospitalists and nurse practitioners who have been granted privileges by the Medical Staff Associate to provide 24/7 coverage for the NICU. Persons Responsible Chief of Neonatology Monitoring Process The Chief of Neonatology ensures a completed monthly schedule that includes coverage with board certified or board eligible neonatology providers. The Medical Staff Associate will continue to monitor that the appropriate number of staff are privileged to provide an appropriate level of care.	6-1-10 6-1-10 June/ July 2010 ongoing
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	3a/b. NICU COVERAGE Based on NNP2's assessment, the Neonatologist did not need to come in. NNP2 did not convey a need for additional assistance at the time of the call. The Neonatologist noted he would have come in if the NNP2 had requested such. NNP2 has been out of a medical leave since May 2010. The CT scan was requested "in the morning" and was ordered on 3/15/10 by the day NNP. The CT scan was ordered at 0857, performed at 9:19am and the preliminary report was entered at 12:42 pm. Permanent Corrective Actions The chief of Neonatology prepares the schedule for the NICU to ensure appropriate neonatology physician and Nurse Practitioner oversight coverage. As of 6/1/10 the NICU has adequate staffing coverage. Monitoring Process The chief of Neonatology ensures a completed monthly schedule that includes coverage with board certified or board eligible neonatology providers. The schedule will be monitored on a monthly basis. Any deficiencies Will be brought to the attention of the Chairman, Dept of Pediatrics who will also notify the President of the PSA as well as the Chief Medical Officer	6-1-10
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		ongoing

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A 338	Continued From page 11 Findings: 1. The medical staff failed in their responsibility to communicate and update the governing body regarding the capability of the NICU advertised as having a community level of care instead of the intermediate level of care designated by CCS. See A049, A288. 2. The medical staff failed to ensure that appointments of appropriate practitioners to the medical staff had been performed in a manner consistent with the hospital bylaws and standards of care. See tags A347, A353. 3. The medical staff failed to ensure patients safety in the NICU due to inconsistent and inadequate coverage by only one neonatologist. See tags A049, A347. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	3b. As above, the NNP2 did not convey the need for additional assistance. This NNP2 continues on a medical leave. Permanent Corrective Actions The NICU standard staffing is 2 hospitalists on for 7A-7P with Neonatology in house or on call 1 hospitalists on for 7P-7A with a Neonatologist on call and available to come in. Persons Responsible Chief of Neonatology Monitoring Process The chief of Neonatology ensures a completed monthly schedule that includes coverage as defined above. 4. CALL SCHEDULES Permanent Corrective Actions The chief of Neonatology ensures that call schedules are available on the intranet. See A049 under Call Board management for additional corrective actions actions applicable to this tag.	6-1-10 ongoing 6-1-10
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347	Persons Responsible Chief of Neonatology Medical Executive Committee Monitoring Process The chief of Neonatology will ensure that the call schedule is posted at least 1 day prior to the end of the month See A049 page 6 under Call Board Management for additional corrective actions applicable to this tag.	9-15-10 and ongoing

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A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	A 347		

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A 347	Continued From page 12 (3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview, the medical staff failed to be accountable in updating the governing body regarding the NICU's current operational status and the quality of medical care being provided to its patients. In addition, the fall incident of Patient 2 failed to show an organized medical staff when a neonatal nurse practitioner was allowed to cover three hospital services with no immediate neonatologist back-up. The failure in organization and accountability could result in potential harm when the level of care being provided to critically ill neonates in the absence of an in-house neonatologist were greater than the NICU personnel were qualified to handle. Findings: 1. Per review of Guidelines for Perinatal Care; 6th edition; co-authored by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists, a national authority setting the standard for perinatal care, designated levels of neonatal care as Levels I - basic, Level II - specialty and Level III - subspecialty. These levels of neonatal care were interpreted by California Children's Services (CCS) as intermediate, community and regional respectively. * The Level I or basic neonatal care dealt with evaluation of healthy infants, neonatal resuscitation and/or stabilize ill newborn infants	A 347	A 347 MEDICAL STAFF ACCOUNTABILITY 1. CCS (California Children's Services) is not a regulatory body and the result of their downgrading the NICU to intermediate level did not reflect a lack of compliance with a regulatory body. Immediate Corrective Actions CEO instructed NICU staff to transfer babies requiring ventilators until CCS community Level status was restored Permanent Corrective Action CCS conducted a survey to assess the NICU's compliance with criteria related to the different levels of care. CCS granted OVMC conditional approval as a CCS Community NICU for six (6) months The Governing Body was updated on the status of the NICU's current operational status and the quality of medical care provided to its patients at a meeting. Persons Responsible Interim Medical Director Chief of Neonatology Chief Executive Officer Monitoring Process Monitoring of CCS status and maintenance of CCS designation is the responsibility of the Chief of Neonatology. There are requirements in the CCS standards to provide reports and data regularly regarding standards compliance and neonatal outcomes. Once full, non conditional approval is achieved, monitoring of compliance will be done by the Chief of Neonatology with oversight by the Assistant Hospital Administrator. Any changes in CCS status will be communicated to the Governing Body via the regularly scheduled quarterly meetings.	5-12-10 6-10-10 7-1-10 5-18-10

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A 347	Continued From page 13 until the necessary transfer to a higher level of care. * The Level II or specialty care nurseries could provide care to moderately ill infants with or without need for assisted ventilation for brief duration. At a hospital with a level II nursery, a board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine should be chief of the neonatal care service. * The Level III or subspecialty NICU should care for severe high risk infants with complex and critical illnesses. Other neonatologists who practice in the subspecialty NICU should have qualifications similar to the chief of the service (a board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine). A neonatologist should be available for consultation 24 hours per day. A neonatologist should be in-house to manage neonatal emergencies. On 6/2/10, review of the hospital's website indicated that since 7/8/05, the hospital's NICU had been advertised as providing a community level of care. A memo written by an Assistant Hospital Administrator on 6/2/10 revealed on 9/14/09, the NICU Medical Director, a neonatologist, retired. On 9/15/09, a pediatrician who was board-eligible, not a board-certified neonatologist, became the Interim Medical Director for more than two months. On 11/21/09, a board-certified neonatologist assumed the role of the Medical Director. On 6/2/10, review of a notification letter from CCS addressed to the former NICU Medical Director	A 347		

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A 347	Continued From page 14 with a copy sent to the former CEO, dated 11/20/08, revealed that the provisional approval for the hospital's NICU on a community level was changed to conditional approval as an intermediate NICU for a period of four months. On 6/2/10 review of the hospital's table of correspondence with CCS from 2005 to the present date showed that the hospital failed to comply with the CCS requirements downgrading the hospital's NICU to intermediate level. However, record review of 5 of 30 infants cared for in the NICU revealed that the NICU continued to care for infants requiring level IIB to level III care (Patients 1, 2, 4, 5, and 7). 2. Further review of the neonatologist's NICU schedule (3/10-5/10) and personnel record review, revealed the hospital's NICU had one board-certified neonatologist alternating a weekly schedule with a pediatrician who was board-eligible to be a neonatologist. On 5/3/10, 5/30/10 and 5/31/10, there were no neonatologist coverage on the schedule for consultation. By the month of 6/10, the board-eligible neonatologist was on vacation leaving one board-certified neonatologist available for NICU consultation but with no neonatologist in-house on a 7-day/24-hour basis to manage neonatal emergencies. In an interview with the NICU Medical Director on 6/3/10 at 1330 hours, he stated that schedule coverage provided by pediatrician hospitalists had been helpful but his schedule remained tight being the sole board-certified neonatologist. 3. a. Per record review of Patient 2 on 6/2/10, the patient was a 995 gram product of a 26 and 4/7	A 347	2. NICU STAFF Permanent Corrective Actions The interim Chief Medical Officer hired a chief of Neonatology The chief of Neonatology hired five (5) additional NICU board certified staff to address the staffing needs of the NICU The Medical Executive Committee approved the appointment of these physicians. There are now a total of seven (7) board certified neonatologists, who provide in house and on call coverage, as mandated by the Level III status, who are assisted by 12 hospitalists and nurse practitioners who have been granted privileges by the Medical Staff Associate to provide 24/7 coverage for the NICU. Persons Responsible Chief of Neonatology Monitoring Process The Chief of Neonatology ensures a completed monthly schedule that includes coverage with board certified or board eligible neonatology providers. The Medical Staff Associate will continue to monitor that the appropriate number of staff are privileged to provide an appropriate level of care.	6-1-10 6-1-10 June/ July 2010 ongoing

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A 347	Continued From page 15 week pregnancy who was on high frequency ventilation on and off from 8/10/09 until 12/8/09. On 11/30/09, the patient had a cardiac arrest when extubated and was placed on assisted ventilation until 12/30/09. On 3/14/10, past 2000 hours, Patient 2 had a fall incident while on a weighing scale. Per nurses notes, NNP2 was notified. NNP2 examined Patient 2 and ordered and reviewed skeletal x-rays to rule out fracture. Per NNP1's notes on 3/15/10, Patient 2 sustained slight bruising to right eye, right forehead and right arm. Per NNP2's notes documented on 3/17/10, as a late entry, the Medical Director and board-eligible neonatologist were both notified after the fall incident of 3/14/10. Patient 2 had been "fussy and crying unable to determine if crying was from pain, wanting to be fed, held or changed." However, neither one of the neonatologists came to personally examine Patient 2. On 3/14/10, a CT scan of the head was recommended by the Medical Director, upon discussion of the fall incident with NNP2, which was ordered on a "now" basis. The CT scan of the brain was not done until the following morning at 0932 hours. It showed no evidence of acute intracranial bleed but widening of the lateral and third ventricle of the brain remained as noted in previous studies. On 6/3/10 at 0930 hours, the Interim CMO was asked why the neonatologist did not come in to examine Patient 2 on the night of the incident. Her response was, "I thought he did." 3. b. Additional documentation by NNP2 on 3/17/10 for the night of 3/14/10 showed she was	A 347	3a/b. NICU COVERAGE Based on NNP2's assessment, the Neonatologist did not need to come in. NNP2 did not convey a need for additional assistance at the time of the call. The Neonatologist noted he would have come in if the NNP2 had requested such. NNP2 has been out of a medical leave since May 2010. The CT scan was requested "in the morning" and was ordered on 3/15/10 by the day NNP. The CT scan was ordered at 0857, performed at 9:19am and the preliminary report was entered at 12:42 pm. Permanent Corrective Actions The chief of Neonatology prepares the schedule for the NICU to ensure appropriate neonatology physician and Nurse Practitioner oversight coverage. As of 6/1/10 the NICU has adequate staffing coverage. Monitoring Process The chief of Neonatology ensures a completed monthly schedule that includes coverage with board certified or board eligible neonatology providers. The schedule will be monitored on a monthly basis. Any deficiencies Will be brought to the attention of the Chairman, Dept of Pediatrics who will also notify the President of the PSA as well as the Chief Medical Officer	6-1-10 ongoing

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A 347	Continued From page 16 the "sole clinician that night for Newborn Nursery, NICU and Labor and Delivery Unit for high risk deliveries and potential admissions. I felt it was appropriate to prioritize patient care according to their needs." When the Interim Chief Medical Officer was interviewed on 6/3/10 at 0930 hours, she stated that she was not aware of the present operational status of the NICU while holding the temporary position for a couple of months. The surveyor attempted twice to interview the NNP2 on 6/4/10 at 1000 hours by phone. No return call was received before the exit conference that afternoon. 4. During an observation tour of the NICU on 5/12/10 at 1120 hours, with the Medical Director of the NICU, the Director of Maternal Child, the Nurse Manager of NICU and RN 7, the call board at the nurses station was observed. The call board listed all the physicians and NPs working in the NICU. There was no information on the board to indicate who was the physician or NP on-call or their contact numbers. When asked how staff would know who to call in an emergency, RN 7 stated the name of the physician on-call was passed on at change of shift. When asked who was physician on-call at this time, the Director of Maternal Child and the Nurse Manager were unable to state. The Medical Director stated the call list was also on the hospital intranet. When asked, the Director of Maternal Child, the Nurse Manager of NICU and RN 7 stated they were not aware the call schedules were available on the intranet.	A 347	3b. As above, the NNP2 did not convey the need for additional assistance. This NNP2 continues on a medical leave. Permanent Corrective Actions The NICU standard staffing is 2 hospitalists on for 7A-7P with Neonatology in house or on call 1 hospitalists on for 7P-7A with a Neonatologist on call and available to come in. Persons Responsible Chief of Neonatology Monitoring Process The chief of Neonatology ensures a completed monthly schedule that includes coverage as defined above. 4. CALL SCHEDULES Permanent Corrective Actions The chief of Neonatology ensures that call schedules are available on the intranet. See A049 under Call Board management for additional corrective actions actions applicable to this tag. Persons Responsible Chief of Neonatology Medical Executive Committee Monitoring Process The chief of Neonatology will ensure that the call schedule is posted at least 1 day prior to the end of the month See A049 page 6 under Call Board Management for additional corrective actions applicable to this tag.	6-1-10 ongoing 6-1-10 9-15-10 and ongoing
A 353	482.22(c) MEDICAL STAFF BYLAWS	A 353		

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A 353	Continued From page 17 The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: This STANDARD is not met as evidenced by: Based on staff interview and record review, the medical staff failed to enforce it's physician supervisory rules for two of two NNPs. This resulted in the potential for unqualified staff to be re-appointed to their advanced practice positions. Findings: On 6/3/10 review of Page 10 of the hospital's Nurse Practitioner Manual, 2009 revealed ongoing peer review would be conducted by the Clinical Supervising Physician by reviewing ten charts twice a year and contributing to the individual's annual performance evaluation. On 6/3/10, review of the two NNP personnel files failed to show evidence that the supervising physicians reviewed 20 patient records cared for by the two NNPs as part of their annual evaluations. On 6/3/10 at 1330 hours, when asked, the NICU Medical Director stated that he reviewed NNP's progress notes on a daily basis but was unaware of his responsibility to document those record reviews as part of the peer review process for re-appointment and performance evaluation of the NNP.	A 353	A353 MEDICAL STAFF BYLAWS Permanent Corrective Actions Nurse Practitioner Ongoing Periodic Performance Evaluation (OPPE) forms were approved by the Medical Executive Committee All Service chiefs were reminded of the requirement to review 10 nurse practitioner charts as part of the credentialing process. Persons Responsible Medical Executive Committee Credentials Committee Monitoring Process At the end of June and December of each year, the Medical Staff Office sends each department chair or NP supervisor a request to provide results of the 10 chart reviews for the previous six months. The results of these audits are reviewed by Quality Management, added to the providers profile, and placed in the reappointment section of the credential file. This is part of the regular ongoing professional performance evaluation process.	6-25-10 6-26-10 ongoing
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	A 385		

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A 385	Continued From page 18 This CONDITION is not met as evidenced by: Based on observation, interview, medical record review and review of hospital P&P, the hospital failed to ensure the organized delivery of nursing services by failing to: Findings: 1. Ensure nursing staff in the NICU evaluated the care needs of their patients in accordance with accepted standards of nursing practice and per hospital policy. See A395 and A405. 2. Ensure the nursing service implemented timely preventative actions to prevent future occurrences for two adverse events. See A288. 3. Ensure packets of breastmilk fortifier were stored in a NICU location where it would not be exposed to cross-contamination. The packets were found on the countertop by the sink where staff and visitors wash their hands, exposing these packets to contamination by the splashing water coming from the sink. See A749 #3. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 385	A385 The hospital has an organized nursing service that provides 24 hour nursing services supervised by registered nurses. The corrective actions for these findings are contained on the following page 19's.	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395		

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A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395		

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A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395		

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A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395		

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A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395		

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A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure consistent adherance to the P&P for	A 395	Monitoring Process Infection Control conducts unannounced Environmental Rounds in the NICU weekly. Any instance of non-compliance is immediately addressed with the Nurse Manager.	5-10 & 9-15-10 and ongoing

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A 395	Continued From page 19 expressed breast milk administration for eight of 30 sampled patients (Patients 1, 4, 6, 13, 16, 23, 25, and 28). This resulted in Patient 1 receiving expressed breast milk from a mother not his own. This had the potential for Patient 1 and the other seven patients to be exposed to infectious diseases such as Hepatitis B and HIV. One of 30 sampled patients was able to push himself off a weighing scale while the nurse caring for him was attempting to complete another task, sustaining bruising to the head (Patient #2) The failure to take timely action to prevent recurrence placed all NICU patients at risk for falls. Findings: 1. On 5/12/10, the California Department of Public Health initiated an onsite complaint investigation which included the allegation a NICU patient was dropped from the scale onto the floor during weighing on 3/14/10. During an interview with the CQO on 5/12/10 at 1150 hours, she provided an investigation report of the incident and confirmed Patient 2 was caught from an accidental slip off a scale on 3/14/10. A photograph of the scale involved showed raised sides covering the length of the scale front and back. The ends of the scale were flat and open. The scale sat a top a metal cart. The medical record for Patient 2 was reviewed on 5/12/10 at 1515 hours. Review of the NICU Daily Progress Note by the NNP dated 3/15/10, showed Patient 2's age was 217 days and weighed 6973 gm (approximately 15 pounds). Review of the nurses' progress notes dated	A 395	ACCIDENTAL SLIP OFF A SCALE Immediate/Permanent Corrective Actions The Clinical Nursing Director revised Policy 512 Patient Safety Measures in the NICU to include the statement that any infant weighing greater than 3000 grams or older than 8 weeks of life must be weighed on the four sided scale. The RN involved received a written confirmation of counseling letter. NICU staff were inserviced on the new policy requirements. The NICU PI first quarter report was revised to include actions taken to address the fall. The 2 sided scales in the NICU were replaced with all 4 sided scales. Persons Responsible Clinical Nursing Director NICU Interim Nurse Manager Monitoring Process Observational audits are conducted by the charge nurse to ensure that all infants in the NICU are weighed on the appropriate scale by the RN staff as required by policy. Audits are conducted twice weekly Results of these audits are reported to the NICU/Nursing performance improvement committee Audits will continue until monitoring demonstrates 100% compliance sustained over 2 months, then monitoring will be done quarterly.	5-25-10 5-25-10 5-13-10 5-18-10 8-2010 6-1-10 and ongoing

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A 395	Continued From page 20 3/14/10 at 2000 hours, showed documentation Patient 2 was bathed, weighed and redressed. "The bed linens were changed with the infant on scale #3, one hand on the infant and one hand tucking the sheet underneath the mattress, when the infant gave one big push and began falling to the floor. Was unable to break part of the fall by grasping legs and buttocks. Upper back area actually touched floor." Review of the NNP progress note, dated as a late entry on 3/17/10, showed an examination following the fall on 3/14/10. The documentation revealed Patient 2 had slight bruising to the right eye and the right lateral forehead, and a small 0.5 cm in length bruise to the right arm. A full body x-ray and a CT scan of the head were ordered. The patient's discharge, planned for the following day, would be delayed for one to two days. During a follow up interview with the CQO on 5/12/10 at 1515 hours, she stated signs had now been placed on the two sided scale "not to be used for larger infants". The CQO stated a four sided scale was available and was to be used for those babies over 3000 gms and/or more than eight weeks old. Prior to this, nothing had been done formally to ensure the scale was not used on larger infants. 2. On 5/12/10, the hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, was reviewed. The purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Documentation showed upon transfer of breast milk to feeding containers	A 395	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050040	A. BUILDING _____ B. WING _____	C 06/08/2010

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A 395	Continued From page 20 3/14/10 at 2000 hours, showed documentation Patient 2 was bathed, weighed and redressed. "The bed linens were changed with the infant on scale #3, one hand on the infant and one hand tucking the sheet underneath the mattress, when the infant gave one big push and began falling to the floor. Was unable to break part of the fall by grasping legs and buttocks. Upper back area actually touched floor." Review of the NNP progress note, dated as a late entry on 3/17/10, showed an examination following the fall on 3/14/10. The documentation revealed Patient 2 had slight bruising to the right eye and the right lateral forehead, and a small 0.5 cm in length bruise to the right arm. A full body x-ray and a CT scan of the head were ordered. The patient's discharge, planned for the following day, would be delayed for one to two days. During a follow up interview with the CQO on 5/12/10 at 1515 hours, she stated signs had now been placed on the two sided scale "not to be used for larger infants". The CQO stated a four sided scale was available and was to be used for those babies over 3000 gms and/or more than eight weeks old. Prior to this, nothing had been done formally to ensure the scale was not used on larger infants. 2. On 5/12/10, the hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, was reviewed. The purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Documentation showed upon transfer of breast milk to feeding containers	A 395	Auditing for each of these measures will continue as such until 100% compliance has been sustained for 2 months. After 2 months of sustained compliance monitoring will be done quarterly.	

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A 395	Continued From page 21 and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. This would be documented on the 24 hour nursing flow sheet. In addition, breast milk bottles would be accepted on admission/transfer from other hospitals provided they were properly labeled. a. On 5/12/10, the California Department of Public Health initiated a complaint investigation which included the allegation that wrong breast milk was given to a NICU infant. During an interview with the CQO on 5/12/10 at 1100 hours, she confirmed Patient 1 was fed breast milk on 3/4/10 that was not from the patient's mother. Review of the Investigation Report revealed Patient 1 had been transferred from an outside hospital on 2/17/10, along with several containers of breast milk. At the time of admission to the NICU, new hospital labels were applied to the containers of milk by the nurse. On 3/4/10 at approximately 1900 hours, it was noted the breast milk used at that feeding was from a different mother. Patient 1's medical record was reviewed on 5/12/10 with the CQO. Review of the NICU 24 hour Nursing Flow Sheet dated 3/14/10, showed expressed breast milk was used for feedings. The CQO confirmed there was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID band of Patient 1 before administration to the baby at 1800 hours.	A 395	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing

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A 395	Continued From page 22 b. The medical record for Patient 25 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed on 3/16/10 the patient was administered expressed breast milk via a bottle at 0700, 1300 and 1500 hours. There was no documented evidence two licensed nurses double checked the label on the breast milk container against the ID band of Patient 25 before administration to the baby. c. The medical record for Patient 13 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed the following: 4/18/10 at 0800, 1100, 2000, 2300, 0200, and 0500 hours; 4/20/10 at 2100, 0000, 0300 and 0600 hours; 4/22/10 at 0800, 1100, 1400, 1700, and 0600 hours; and 4/25/10 at 2345, 0230, and 0530 hours did not show documentation two licensed nurses double checked the label on the breast milk container against the ID band of Patient 13 before administration to the baby. d. The medical record for Patient 4 was reviewed on 6/3/10 at 0845 hours. Review of the NICU 24 hour Nursing Flow Sheets dated 5/8/10 and 5/9/10, showed the patient was administered expressed breast milk via stomach tube at 2000, 2300, and 0200 hours on both days. There was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID band of Patient 4 before administration to the baby. e. Review of the medical record for Patient 23 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow sheets documentation of feeding episodes. Feeding episodes reviewed	A 395	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing

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A 395	Continued From page 22 b. The medical record for Patient 25 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed on 3/16/10 the patient was administered expressed breast milk via a bottle at 0700, 1300 and 1500 hours. There was no documented evidence two licensed nurses double checked the label on the breast milk container against the ID band of Patient 25 before administration to the baby. c. The medical record for Patient 13 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed the following: 4/18/10 at 0800, 1100, 2000, 2300, 0200, and 0500 hours; 4/20/10 at 2100, 0000, 0300 and 0600 hours; 4/22/10 at 0800, 1100, 1400, 1700, and 0600 hours; and 4/25/10 at 2345, 0230, and 0530 hours did not show documentation two licensed nurses double checked the label on the breast milk container against the ID band of Patient 13 before administration to the baby. d. The medical record for Patient 4 was reviewed on 6/3/10 at 0845 hours. Review of the NICU 24 hour Nursing Flow Sheets dated 5/8/10 and 5/9/10, showed the patient was administered expressed breast milk via stomach tube at 2000, 2300, and 0200 hours on both days. There was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID band of Patient 4 before administration to the baby. e. Review of the medical record for Patient 23 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow sheets documentation of feeding episodes. Feeding episodes reviewed	A 395	Auditing for each of these measures will continue as such until 100% compliance has been sustained for 2 months. After 2 months of sustained compliance monitoring will be done quarterly.	

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A 395	Continued From page 23 included expressed breast milk requiring two signature verification by nursing staff. Feeding episodes dated 3/11/10, showed no co-signature verification for two feedings. Feeding episodes dated 3/15/10, showed no co-signature verification for one feeding. Feeding episodes dated 3/20/10, showed no co-signature verification for one feeding. Feeding episodes dated 4/4/10, showed no co-signature verification for seven feedings. Feeding episodes dated 4/16/10, showed no co-signature for four feedings. Feeding episodes dated 4/19/10, showed no co-signature by nursing staff for eight feedings. f. Review of the medical record for Patient 6 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 3/4/10, showed no cosignature verification for two feedings. Feeding episodes dated 3/9/10, showed no co-signature verification for two feedings. Feeding episodes dated 3/12/10, showed no co-signature verification for three feedings. Feeding episodes dated 5/10/10, showed no co-signature verification for one feeding. g. Review of the medical record for Patient 28 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 4/27/10, showed no co-signature verification for three feedings.	A 395	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	5-13-10 6-1-10 6-22-10 6-15-10 and ongoing

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A 395	Continued From page 24 h. Review of the medical record for Patient 16 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 5/2/10, showed no co-signature verification for three feedings.	A 395	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk.	5-13-10
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure nursing staff in the NICU followed the P&P for the handling and identification of expressed mother's breast milk prior to it's administration for eight of 30 sampled patients (Patients 1, 4, 6, 13, 16, 23, 25, 28). This resulted in Patient 1 receiving expressed breast milk from a mother not his own. This had the potential for Patient 1 and the seven other patients to be exposed to infectious diseases such as Hepatitis B and HIV. Findings: The hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, was reviewed. The purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while	A 405	The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother. Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	6-1-10 6-22-10 6-15-10 and ongoing

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A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of facility documents, the hospital failed to ensure nursing staff in the NICU followed the P&P for the handling and identification of expressed mother's breast milk prior to it's administration for eight of 30 sampled patients (Patients 1, 4, 6, 13, 16, 23, 25, 28). This resulted in Patient 1 receiving expressed breast milk from a mother not his own. This had the potential for Patient 1 and the seven other patients to be exposed to infectious diseases such as Hepatitis B and HIV. Findings: The hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, was reviewed. The purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while	A 405		

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A 405	Continued From page 25 minimizing the chance of contamination or error. Documentation showed upon transfer of breast milk to feeding containers and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. This would be documented on the 24 hour nursing flow sheet. In addition, breast milk bottles would be accepted on admission/transfer from other hospitals provided they are properly labeled. On 5/12/10, the California Department of Public Health initiated a complaint investigation which included the allegation breast milk was given to the wrong infant in the NICU. 1. During an interview with the CQO on 5/12/10 at 1100 hours, she confirmed Patient 1 was fed breast milk on 3/4/10 that was not from the patient's mother. Review of the Investigation Report revealed Patient 1 had been transferred from an outside hospital on 2/17/10, along with several containers of breast milk. New hospital labels were applied to the containers by the nurse at the time of admission to the NICU. On 3/4/10 at approximately 1900 hours, it was noted the breast milk used at this feeding was from a different mother. Patient 1's medical record was reviewed on 5/12/10 with the CQO. Review of the NICU 24 hour Nursing Flow Sheet dated 3/14/10, showed expressed breast milk was used for feedings. The CQO confirmed there was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID	A 405	BREAST MILK MISADMINISTRATION ITEMS 1-8 See also corrective actions under A288 Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk. Auditing for each of these measures will continue until 100% compliance has been sustained for 2 months. Then monitoring will be done quarterly.	5-12-10 6-1-10 6-15-10 and ongoing

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A 405	Continued From page 26 band of Patient 1 before administration to the baby at 1800 hours. 2. The medical record for Patient 25 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed, on 3/16/10, the patient was administered expressed breast milk via a bottle at 0700, 1300 and 1500 hours. There was no documented evidence two licensed nurses double checked the label on the breast milk container against the ID band of Patient 25 before administration to the baby. 3. The medical record for Patient 13 was reviewed on 6/3/10 at 1235 hours. Review of the NICU 24 hour Nursing Flow Sheets showed the following: 4/18/10 at 0800, 1100, 2000, 2300, 0200, and 0500 hours; 4/20/10 at 2100, 0000, 0300 and 0600 hours; 4/22/10 at 0800, 1100, 1400, 1700, and 0600 hours; and 4/25/10 at 2345, 0230, and 0530 hours did not show documentation two licensed nurses double checked the label on the breast milk container against the ID band of Patient 13 before administration to the baby. 4. The medical record for Patient 4 was reviewed on 6/3/10 at 0845 hours. Review of the NICU 24 hour Nursing Flow Sheets dated 5/8/10 and 5/9/10, showed the patient was administered expressed breast milk via stomach tube at 2000, 2300, and 0200 hours on both days. There was no documentation to show two licensed nurses double checked the label on the breast milk container against the ID band of Patient 4 before administration to the baby. 5. Review of the medical record for Patient 23 began on 6/3/10, and showed on the NICU 24	A 405		

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A 405	Continued From page 27 hour Nursing Flow sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signature verification by nursing staff. Feeding episodes dated 3/11/10, showed no co-signature verification for two feedings. Feeding episodes dated 3/15/10, showed no co-signature verification for one feeding. Feeding episodes dated 3/20/10, showed no co-signature verification for one feeding. Feeding episodes dated 4/4/10, showed no co-signature verification for seven feedings. Feeding episodes dated 4/16/10, showed no co-signature for four feedings. Feeding episodes dated 4/19/10, showed no co-signature by nursing staff for eight feedings. 6. Review of the medical record for Patient 6 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 3/4/10, showed no co-signature verification for two feedings. Feeding episodes dated 3/9/10, showed no co-signature verification for two feedings. Feeding episodes dated 3/12/10, showed no co-signature verification for three feedings. Feeding episodes dated 5/10/10, showed no co-signature verification for one feeding. 7. Review of the medical record for Patient 28 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 4/27/10, showed no co-signature	A 405		

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A 405	Continued From page 28 verification for three feedings. 8. Review of the medical record for Patient 16 began on 6/3/10, and showed on the NICU 24 hour Nursing Flow Sheets documentation of feeding episodes. Feeding episodes reviewed included expressed breast milk requiring two signatures by nursing staff. Feeding episodes dated 5/2/10, showed no co-signature verification for three feedings.	A 405	Immediate Corrective Action The physician was requested to add an addendum to the medical record to record the results of the wrong mother's laboratory tests as required by hospital policy. Permanent Corrective Actions The interim Chief Nursing Officer instructed all nurse managers to ensure that they inform all staff to document events, including notification of actions taken, as appropriate in the patient's medical record. They were also asked to document this discussion in their next staff meeting. The NICU Nurse Manager discussed this with staff. The Interim Chief of NICU sent a memo to all NICU providers on medical chart documentation, including requirements to be accurate and precise. Persons Responsible Chief of Neonatology Clinical Nursing Director	5-14-10 7-27-10 7-28&30 2010 5-21-10
A 449	482.24(c) CONTENT OF RECORD The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on interview, medical record review and review of hospital P&P, the hospital failed to ensure the medical record for one of 30 sampled patients (Patient 1) contained information regarding the occurrence of the misadministration of breast milk to the patient from another mother not his own. There was no documentation to show if care was provided to the patient after the incident, follow up regarding the investigation of the infectious status of the source mother or a plan for follow up of the patient after discharge. Findings: The hospital's P&P Breast Milk Misadministration Policy dated 9/26/06, showed the purpose of the policy was to provide guidelines for action when an infant was fed human milk from a mother other than his/her own. Key points included: the physician would review the source mother's chart	A 449		

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A 449	Continued From page 29 for maternal history; consent forms would be obtained for testing both the source mother and the recipient mother for the Hepatitis B Surface Antigen, HIV, and HTLV (Human T-lymphotropic virus - a virus that has been implicated in several kinds of diseases), the physician would obtain informed consents for the HIV test from the source mother and the recipients's mother if results were not available in the medical record; the physician would notify the primary physician of the recipient infant to provide follow up care as needed; and the incident would be discussed with both families in a timely and confidential manner. In addition, the following would be noted on the recipient infant's medical record: the date of the occurrence, laboratory studies sent, and that follow up laboratory tests on the infant might be needed; and action taken according to the recipient's physician's orders. On 5/12/10, the California Department of Public Health initiated a complaint investigation which included the allegation that wrong breast milk was given to a NICU infant. During an interview with the CQO on 5/12/10 at 1100 hours, she confirmed Patient 1 was fed breast milk on 3/4/10 that was not from the patient's mother. Review of the Investigation Report revealed Patient 1 had been transferred from an outside hospital on 2/17/10, along with several containers of breast milk. New hospital labels were applied to the containers by the nurse at the time of admission to the NICU. On 3/4/10 at approximately 1900 hours, it was noted the breast milk used at that feeding was from a different mother.	A 449	Monitoring Process Events are reported to the on line Patient Safety Net.Risk Management staff review all events. Risk Management staff will randomly review nursing and progress note documentation of events reported to ensure documentation in the medical record. Deficiencies will be addressed with the appropriate supervisory staff. Results of reviews will be reported to the Risk Management Committee.	6-10 and ongoing

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A 449	Continued From page 30 On 5/12/10 at 1645 hours, the Chief Quality Officer was asked why the nurses' notes failed to show the misadministration of breast milk to Patient 1. The physician's progress notes and discharge history and physical for the patient dated 4/19/10 was reviewed. She then acknowledged she was unable to locate documentation to show the misadministration of breast milk and whether the event was ever discussed with the parents of Patient 1. She added the information should include the infectious status of the source mother or whether an updated infection status of the patient's mother was obtained, as per the hospital's P&P. The Chief Quality Officer said the source mother's history and infectious disease status had been reviewed by Patient 1's physician and Patient 1's parent informed; however, none of this information was recorded in the patient's medical record.	A 449	Our review of the CT scan order documentation shows that the CT scan was ordered STAT on 3/15/10 at 0857, it was performed at 0919 and the preliminary report was available at 1242. The NNP2 documentation in the medical record (late entry)notes that the CT was to be ordered "in the morning". The NNP2 has been on medical leave since May 2010.	6-10-2010
A 529	482.26(a) SCOPE OF RADIOLOGIC SERVICES The hospital must maintain, or have available, radiologic services according to the needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to follow their P&P on prioritizing a CT scan of the brain ordered to be done on a "now" basis for one of 30 sampled patients (Patient 2). The failure to do so could result in a delay of life-saving medical or surgical diagnoses and interventions. Findings: On 6/4/10, review of the hospital's P&P on	A 529	Immediate/Permanent Corrective Actions Turn around times for STAT CT are monitored. Deficiencies are addressed in the Radiology Department of performance improvement(PI)meetings and actions are taken to address any deficiencies. Person Responsible: Chief of Radiology Monitoring Process: Random CT exams are audited each month and the median times are compiled and reported in PI meetings The median turnaround times from order to preliminary result have been consistently less than 3 hours.	ongoing ongoing

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A 529	Continued From page 31 Ordering Radiological Sciences, letter g stated, "Stat" requests should be limited to true emergencies which would require an immediate radiologic study in order to proceed with patient care. Letter h stated, an "emergency request" should be the priority over routine examinations and would be expedited within three hours. Per record review of Patient 2 on 6/2/10, Patient 2 had a fall incident while being weighed on an infant scale on 3/14/10 at approximately 2000 hours per the nurse's notes. NNP2, who was in-house, was informed and examined Patient 2. Upon discussion of the incident with the Medical Director, it was recommended that a CT scan of the brain was ordered "now." However, the CT scan of the brain for Patient 2 was done the following morning at 0932 hours. No other documentation was presented by the hospital as to why the CT scan was delayed. On 6/8/10 at 1400 hours, the P&P on stat CT scan was received and discussed with CQO. It was acknowledged that the CT scan was delayed for more 12 hours.	A 529		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview, medical record review and review of hospital documents, the hospital failed to ensure P&Ps regarding the prevention and control of infections and	A 749		

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A 749	Continued From page 32 communicable diseases were implemented in the NICU. The P&P for the handling and identification of expressed breast milk prior to it's administration was not implemented for eight of 30 sampled patients (Patients 1, 4, 6, 13, 16, 23, 25, 28). The P&P for the misadministration of breast milk was not implemented when no documentation was located in the Patient 1's medical record to show the patient's parents were aware of the incident, the source mother of the breast milk was tested and was free of communicable diseases, and a plan was in place for follow up of the patient. These failures had the potential for Patient 1 and the seven other patients to be exposed to infectious diseases such as Hepatitis B and HIV. The hospital also failed to develop and maintain a system to identify employees who were found not to have current annual health screening requirements as evidenced by expired Tuberculin skin test status. The failure increased the potential for these fragile patients, other health care staff, and visitors to be at risk for communicable disease. In addition, packets of breastmilk fortifier were exposed to contamination by splashing water when stored on a countertop in close proximity to the NICU sink. Findings: 1. On 6/4/10, review of hospital policy titled: Medical Evaluation - County Workforce members, showed the policy to provide its workforce with a safe and healthy environment. Medical clearances and annual medical screenings would be provided and no person would be allowed to	A 749	A749 INFECTION CONTROL OFFICER RESPONSIBILITIES 1. Respiratory Therapy Practitioner Clearance Immediate Corrective Actions The respiratory therapist in question completed FIT testing and ppd and was cleared through employee health services. Permanent Corrective Actions The DHS Employee Health Clearances and Licensing Policies were reviewed and revised effective 5/3/10 Each hospital department was surveyed to ensure they have up to date policies on compliance with the DHS Employee Health Clearance Policy The DHS policy was converted to a ValleyCare policy and submitted for approval Persons Responsible Individual Managers CEO Monitoring Process Employee Health Services maintains a database of workforce members' annual clearance dates. Prior to the expiration of the annual health screening, workforce members may be given a 30 day reminder to comply. Workforce members who do not comply are given a "direct order" letter indicating they have five (5) days to comply or face discipline up to and including discharge. A copy of the letter is provided to the workforce member's supervisor for action.	6-4-10 5-3-10 7/10 9-17-10 ongoing ongoing

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A 749	Continued From page 33 work inside the hospital without appropriate documentation of medical clearance or required medical evaluation. Review of the hospital's list of employees and their annual date of compliance with annual physicals and medical examinations included tuberculin skin testing. If the employee was not current in the annual medical review requirements, 'NOT CLEARED' was documented to the right of the employee number. Review of RCP 1's (Respiratory Care Practitioner) personnel file showed RCP 1's employment number was listed as 'NOT CLEARED.' A tour of the NICU was conducted on 6/2/10 and 6/3/10. The staff stated the census was six. All babies were identified as having low birth weights and prematurity. RCP 1 was identified as the the respiratory care practitioner assigned to the NICU. He was observed interacting and caring for an infant. RCP 1 was not wearing a mask. An interview with the Associate Administrator was conducted on 6/4/10 at 1300 hours. The Associate Administrator reported RCP 1's annual PPD and fit testing requirements had expired on 4/30/10. An interview with the RCP supervisor was conducted on 6/4/10 at 1305 hours. The supervisor stated he reviewed the health notification memo and RCP 1 was not on it. He stated he reviewed the annual medical clearance listings as of 5/17/10 and RCP 1 was not listed as not being cleared. He admitted he was not aware RCP 1 was not cleared to work. When asked where RCP 1 worked in the hospital, he replied RCP 1 worked exclusively in NICU. The	A 749		

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A 749	Continued From page 34 supervisor stated a letter would be issued not allowing RCP 1 to work until clearance was obtained. Review of the hospital's respiratory care services monthly employee schedules for the months of May 2010 and June 2010 was conducted. RCP 1 was documented as having worked fourteen, twelve hour shifts, for the month of May 2010, and one twelve hour shift for the month of June 2010. A document titled, Low Birthweight in Newborns) 2005, Children's Hospital Boston, showed babies with low birth weight were at increased risk for complications. The article showed the baby's tiny body was not strong and might have a harder time eating, gaining weight, and fighting infection. In addition, the document showed this population being prone to breathing problems such as respiratory distress syndrome (a respiratory disease of prematurity caused by immature lungs). 2. The hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, showed the purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Upon transfer of breast milk to feeding containers and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. The hospital's P&P Breast Milk Misadministration	A 749	2. BREAST MILK MISADMINISTRATION Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk.	5-13-10
			The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately	6-1-10
			Policy: Collection Storage and Handling of a Mother's Breastmilk for her own Infant was revised to include requirements for properly labeling with pre-printed hospital labels and a process for verification of the labels with the mother.	6-22-10
			Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager	
			Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff.	6-15-10 and ongoing
			The charge nurse will conduct open medical record reviews twice weekly to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk.	

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A 749	Continued From page 34 supervisor stated a letter would be issued not allowing RCP 1 to work until clearance was obtained. Review of the hospital's respiratory care services monthly employee schedules for the months of May 2010 and June 2010 was conducted. RCP 1 was documented as having worked fourteen, twelve hour shifts, for the month of May 2010, and one twelve hour shift for the month of June 2010. A document titled, Low Birthweight in Newborns) 2005, Children's Hospital Boston, showed babies with low birth weight were at increased risk for complications. The article showed the baby's tiny body was not strong and might have a harder time eating, gaining weight, and fighting infection. In addition, the document showed this population being prone to breathing problems such as respiratory distress syndrome (a respiratory disease of prematurity caused by immature lungs). 2. The hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, showed the purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Upon transfer of breast milk to feeding containers and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. The hospital's P&P Breast Milk Misadministration	A 749	Auditing for each of these measures will continue as such until 100% compliance has been sustained for 2 months. After 2 months of sustained compliance monitoring will be done quarterly.	

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A 749	Continued From page 34 supervisor stated a letter would be issued not allowing RCP 1 to work until clearance was obtained. Review of the hospital's respiratory care services monthly employee schedules for the months of May 2010 and June 2010 was conducted. RCP 1 was documented as having worked fourteen, twelve hour shifts, for the month of May 2010, and one twelve hour shift for the month of June 2010. A document titled, Low Birthweight in Newborns) 2005, Children's Hospital Boston, showed babies with low birth weight were at increased risk for complications. The article showed the baby's tiny body was not strong and might have a harder time eating, gaining weight, and fighting infection. In addition, the document showed this population being prone to breathing problems such as respiratory distress syndrome (a respiratory disease of prematurity caused by immature lungs). 2. The hospital's P&P, Collection, Storage and Handling of a Mother's Milk for Her Own Infant dated 2/12/09, showed the purpose of the policy was to provide guidelines for the collection, storage, and handling of breast milk to optimize nutritional and immunological protection while minimizing the chance of contamination or error. Upon transfer of breast milk to feeding containers and before administration, two licensed personnel must verify proper identification, double checking the infant's name, date of birth and medical record number between the original container label and the infant band. The hospital's P&P Breast Milk Misadministration	A 749	BREAST MILK MISADMINISTRATION ITEMS 1-8 See also corrective actions under A288 Immediate/Permanent Corrective Actions The Clinical Nursing Director sent a memo to all NICU nursing staff reminding them of the requirements to co-sign the 24-hour Nursing Flow Sheet to evidence their double check of the infant's correct breast milk. The Clinical Nursing Director and Interim Nurse Manager created a log book to document receipt of breast milk brought into the NICU and to ensure that breast milk will be immediately verified and labeled appropriately Persons Responsible Clinical Nursing Director Interim NICU Nurse Manager Monitoring Process The charge nurse will review the log book entries each shift to ensure completion. If the information is not complete, the Charge Nurse will provide immediate feedback to the involved staff. The charge nurse will conduct open medical record reviews to assess compliance with the double signatures on the NICU flow sheet immediately prior to the administration of breast milk. Auditing for each of these measures will continue until 100% compliance has been sustained for 2 months. Then monitoring will be done quarterly.	5-12-10 6-1-10 6-15-10 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050040	A. BUILDING _____ B. WING _____	C 06/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAC/OLIVE VIEW-UCLA MEDICAL CENTER	14445 OLIVE VIEW DRIVE SYLMAR, CA 91342

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A 749	Continued From page 35 Policy dated 9/26/06, showed the purpose of the policy was to provide guidelines for action when an infant was fed human milk from a mother other than his/her own. Key points included: the physician will review the source mother's chart for maternal history; consent forms will be obtained for testing both the source mother and the recipient mother for blood borne; the physician will notify the primary physician of the recipient infant to provide follow up care as needed; and the incident will be discussed with both families in a timely and confidential manner. In addition, the following will be noted on the recipient infant's medical record: the date of the occurrence, laboratory studies sent, and that follow up laboratory tests on the infant may be needed; and action taken according to the recipient's physician's orders. These policies and procedures to prevent and control infectious diseases were not implemented for eight of 30 sampled patients (Patients 1, 4, 6, 13, 16, 23, 25, 28). See A404. 3. During a tour of the NICU on 6/3/10 at 1330 hours conducted with the NICU Medical Director, packets of breast milk fortifier were noted stored on the countertop by the sink where staff, including visitors, wash their hands. The location of the breast milk fortifier exposed these packets to contamination by the splashing water coming from the sink.	A 749	Immediate Corrective Actions Breast Milk fortifier is no longer kept on the counter by the sink. It is now kept at the patient's bedside. Persons Responsible NICU Interim Nurse Manager Infection Control Monitoring Process Infection Control conducts unannounced Environmental Rounds in the NICU weekly. Any instance of non-compliance is immediately addressed with the Nurse Manager.	6-3-10 5-10 & 9-15-10 and ongoing